TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Jack P. Mitchell, D.C.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-17-3531-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 4, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Documentation submitted with the complete medical bill documents a designated doctor examination as ordered by the TDI/DWC for the purpose of establishing Maximum Medical Improvement, providing an impairment rating, and an Extent Issue."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was originally reviewed on June 24, 2017 where it was determined that $1100 was owed for the exam and that was paid back on 6/27/2017. The bill was reviewed again on August 18, 2017; where it was determined that an additional $100 was/is owed. Check number 32290263 was issued in the amount of $100 on 8/19/2017."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 30, 2017	Designated Doctor Examination	$150.00	$50.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine extent of injury performed on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Workers' compensation jurisdictional fee schedule adjustment.

- 2 – The charge for the procedure exceeds the amount indicated in the fee schedule.

Issues

1. What is the service considered in this dispute?
2. Is Jack P. Mitchell, D.C. entitled to additional reimbursement for the service considered in this dispute?

Findings

1. Dr. Mitchell is seeking an additional reimbursement of $150.00 for a designated doctor examination to determine the extent of the compensable injury, represented by procedure code 99456-WP-W6, performed on May 30, 2017. Therefore, this is the only service considered in this dispute.
2. Per 28 Texas Administrative Code §134.235 states, in relevant part:

   > The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports…

   While the submitted documentation does not include a copy of the designated doctor's report, the insurance carrier did not make any assertions that the service considered in this dispute was not performed. Therefore, the maximum allowable reimbursement for this examination is $500.00.

   Per Explanation of Bill Review dated June 27, 2017, the insurance carrier reimbursed $350.00 for the service in question. The insurance carrier provided an Explanation of Bill Review dated August 19, 2017, which shows an additional reimbursement of $150.00 for the service in question. However, the insurance carrier stated in its response regarding the dispute in question that "it was determined that an additional $100 was/is owed. Check number 32290263 was issued in the amount of $100 on 8/19/2017." Therefore, the division concludes that an additional $50.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $50.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $50.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 6, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.